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A PATIENT EDUCATION CENTER IN THE US ARMY COMMUNITY
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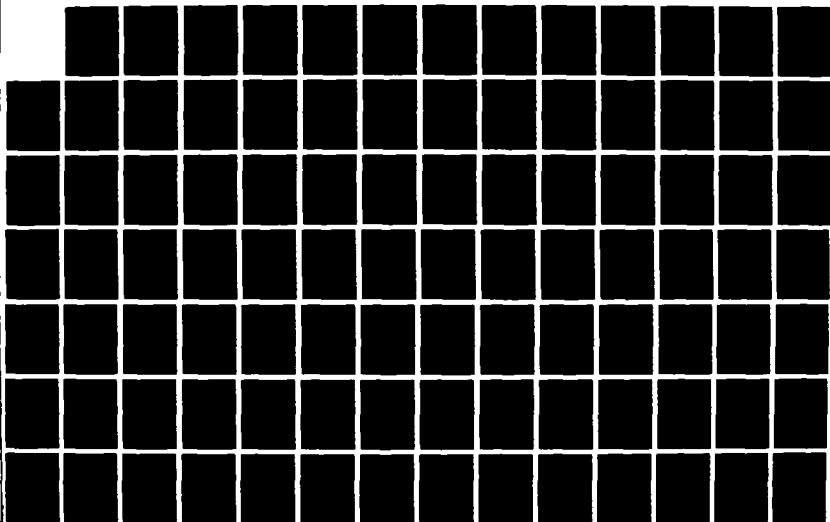
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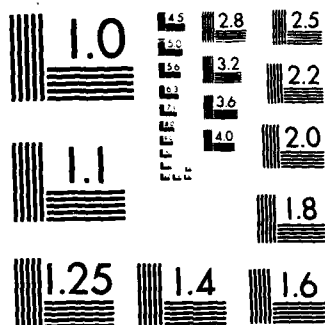
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A PATIENT EDUCATION CENTER IN THE
U.S. ARMY COMMUNITY HOSPITAL,
FT. POLK, LOUISIANA

A Problem Solving Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Hospital Administration

By

Major John A. Williams, MSC

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CHAPTER I

INTRODUCTION

Background Information

Ft. Polk is a military reservation in rural West Central Louisiana. Its U.S. Army Community Hospital (USACH) is a 180-bed, Joint Commission on Accreditation of Hospitals (JCAH)-accredited facility. The mission of this USACH is to support the 5th Infantry Division (Mechanized) and its associated nondivisional units (Ft. Polk). As the largest military medical treatment facility in the state of Louisiana, the catchment area geographically covers the entire state and 41,339 health care beneficiaries: 12,227 active duty members, 19,062 dependents of active duty personnel, 4,000 retired members, and 6,000 dependents of deceased or retired military personnel.

The immediate surrounding medical community includes three small hospitals within one-half hour's drive, containing 28 beds, 54 beds, and 88 beds. The nearest medical facilities with any degree of sophistication are in Alexandria and Lake Charles, Louisiana. They are a one-hour drive and a one-and-a-half-hour drive from Ft. Polk, respectively.

The current facility is contained in over 100 buildings. It is a French-style cantonment complex which was constructed in 1941, in less than four months. After entering a fifth decade in temporary buildings, the staff and the patients may look forward to a new facility. As of May, 1980, the construction of the new facility was 31 percent

complete, with occupancy scheduled for October, 1982. For the new facility, Congress appropriated \$44.6 million. Of that appropriation, \$2.5 million are for fixed equipment. Above that appropriation, the Office of The Surgeon General has designated an additional \$6.7 for nonfixed equipment (MEDCASE).

Identification of the Problem

The current status of patient education was identified as a problem after an analysis of the experiences during and after the implementation of the enlisted SQT (Skill Qualification Test) system. Virtually every facet of the educational process within the boundaries of this health care treatment facility is decentralized and dependent upon the initiative of the individual concerned. This includes but is not necessarily limited to continuing medical education (CME) of professional staff, inservice education of paraprofessional and administrative staffs, military occupational specialty-specific education of enlisted personnel (SQT), military-specific education of officer and enlisted personnel, and general recurring mandatory training of civilian and military personnel (i.e., SAEDA: U.S. Army regulations and guidelines regarding conflict of interest; identification of and precautions against heat and/or cold, injury, etc.).

Due to the breadth of the educational spectrum, the responsible individuals in the major functional areas are evaluating and, as necessary, adjusting their area or topic educational process. For instance, the responsibility of CME has been formally identified as an additional duty of the chief of Professional Services; inservice education of

nursing personnel has remained with the Nursing Education and Training Division; inservice education of the administrative personnel remains with the members' respective functional areas; military-specific and general mandatory training remains with the Plans, Operations, and Training Division. Education in its broadest sense remains fragmented.

The responsibility for patient education has been traditionally fragmented among services, clinics, and wards. As a result of this decentralization, any patient education within the current organization is totally dependent upon the initiative of the individual physician or nurse. Those individuals that vigorously pursue patient education as an overtly integral part of their total treatment of the patient have developed miniature patient education programs which are oriented toward the specific interests and needs of their clinic or ward population. For example, the Family Practice clinics and the Obstetrics and Gynecology Clinic have independently developed prenatal programs for the pregnant woman. The desire to provide the total spectrum of health care to their unit-specific patient population is admirable. However, in this attempt to meet the patient's total needs, the efficiency of the education provided the patient and the economy of the resources required to provide this education appear to be secondary to retaining control over the total treatment process. While it is not questioned that physicians want and should retain control over the education of their patients,¹ it is not clear whether or not the physicians and the nurses in this hospital have consulted with the physicians and the nurses outside their respective clinics/wards concerning the development and the utilization of clinic- or ward-specific patient education programs. Resources,

educational aids, personnel, and equipment have, for the most part, not been shared. The area- or the ward-specific programs have been totally independent of one another.

It is the personal objective of the hospital commander to establish a patient education center in the current hospital facility which will be compatible with the new facility. (See Appendix A for definitions appropriate to this study.) The responsibility for the current facility was originally assigned to the Consumer Health Educational Panel (CHEP). Under this charter, the CHEP has directed the majority of its efforts toward the establishment of a patient education center. The CHEP informally surveyed the current physical plant for an area which could be utilized in the initial efforts with minimal or no start-up costs. It was determined by the CHEP that, as the patient education concept becomes accepted and thus supported by the staff, any increase to or relocation of the physical site within the current facility could be addressed at that time.

A recently assigned field grade nurse was given the primary duty position of patient education coordinator. Her initial responsibilities were to survey patient education as it is being accomplished in the hospital, determine common literature requirements, initiate a central library for the common literature requirements, and begin, as necessary, to develop common patient education programs. Upon the recommendation of the CHEP, the commander directed the patient education coordinator to locate the patient education center in the current Outpatient Clinic. The initial center is comprised of three small offices (approximately 22 feet by 9 feet, 14 feet by 9 feet, and 8 feet by 6 feet). For the

development phase of a patient education program, the physical space appears adequate. Office furniture has been hand receipted from within hospital resources. Administrative support for the patient education center (i.e., the coordinator) is dependent upon which clerk or secretary is willing to assist the coordinator.

As a result of the command support of the patient education process, several of the more active proponents of patient education voluntarily formed a subcommittee of the CHEP for the express purpose of developing prototype models of disease- and injury-specific patient education. As an additional duty and entirely within their own clinical resources, the committee members have focused their energies toward developing patient education programs for what they consider to be two of the more common disease entities of the patients (diabetes mellitus and hypertension). The composition of this voluntary committee includes a family physician, a clinic head nurse, a medical practitioner, a clinical dietitian, and the newly appointed patient education coordinator. As implied above, this voluntary committee's intention is to formulate, as personal resources permit, prototype models which are acceptable to the medical and the nursing staffs. It is recognized that, without this support, the chance for success for any program would be greatly reduced.²

Conditions Which Prompted the Study

7-20-72 With the primary objective of the patient education coordinator and the CHEP being to establish an operating patient education center in the current facility, minimal efforts have been directed toward the integration and the coordination of patient education and a patient

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today, as a national health priority.³ If design changes are to be made to accommodate the patient education center concept, it is to the advantage of the user and the taxpayer that such changes be made as soon as practicable. The closer the design modification is to the completion of the project and the occupancy of the facility, the more expensive it will be.

needs of the community and the staff will be addressed as they relate to a particular situation.

Statement of the Problem

The problem is to determine the patient education requirements for the new hospital. The requirements include, but need not be

Required: workspace layout; hospital; general; furniture; etc. etc. etc.
 design; etc. etc. etc.

limited to, workload predictions, organizational structure (centralized versus decentralized), manpower, equipment, and physical space.

Purpose of the Study

The purpose of this study is to investigate the possible alternatives for implementation of a patient education center in the new facility and to determine which of the alternatives considered would be the best method for that implementation.

Assumptions and Limitations

Additional resource requirements are generally accepted as a limiting factor with a new or increased mission. This assumption is not expected to change with respect to personnel, equipment, and physical space requirements. Any new manpower requirements must be supportable from within current manpower authorizations. Any requests for additional authorizations to support a hospital-generated mission requirement would be expected to meet with minimal success.

Funding for new hospital equipment requirements is not expected to be a limiting factor. Equipment requirements for the support of patient education in the new hospital will be available through new hospital funds. New hospital equipment funds are separate from current MEDCASE monies. As such, they have been designated for use at the new facility. The budgetary acronym used to refer to new hospital equipment funds is BLIC F (Basic Line Item Code F). The acronym for MEDCASE funds is BLIC R.

The relative ease of using BLIC F funds is a result of those funds already being available to the hospital. The major hurdle in the

BLIC F approval process is obtaining the approbation of the hospital commander. Funding for a patient education center in the current facility may not be as easy to obtain if BLIC F funds cannot be used. That equipment which can be shown to be transferable to the new facility while continuing to meet any state-of-the-art strictures may be eligible to be purchased via BLIC F. That equipment which cannot meet those requirements must be purchased through normal MEDCASE procedures. The major hurdles in MEDCASE requests are that they must compete with the normal operational demands of the current facility and then the hospital's total MEDCASE requirements must compete with all other Health Services Command (HSC) treatment facilities for a share of the HSC MEDCASE budget.

Since the initiation of this project, the reliability of the available workload data has been questioned. During the recent JCAH accreditation survey, it was observed by the survey team that patient education is not being adequately documented in the patient charts.⁵ As such, any workload determination must be a composite of that documentation which is available and the subjective evaluation of the current literature and the current staff's opinions.

Objectives

An initial objective of this study was to develop a data base which would be useful in the evaluation of the alternatives as well as in the development of patient education programs at this USACH (whether in a centralized or a decentralized mode). A second objective of this study is to compare and contrast the alternatives presented. Finally,

the third objective is to select and make recommendations as to the specific course of action which should be taken by this USACH in implementing a patient education center in the new facility.

Criteria

The criteria utilized in this study are, for the most part, the resources requirements for patient education: (1) workload, (2) manpower, (3) equipment, and (4) physical space. A fifth criterion for measurement is a subjective evaluation as to the real or the potential quality of patient education under each alternative.

Factors Bearing upon the Problem

Before one embarks on a course of action that may result in the expenditure of resources, one must ascertain the current situation and select the best alternative from those which are available. A commitment to expend resources must be based upon fact or, as a minimum, upon logical deduction from that information which is available.

Even though it is the personal goal of the commander to establish a patient education center in the current facility, this study was undertaken with the understanding that there are three general alternatives. The first alternative is that patient education at this USACH could remain in its traditionally decentralized mode (no change). The second alternative is the immediate institution of a totally centralized patient education system with maximum patient education presented via a systems-oriented patient education center (immediate change). The third alternative is a flexible compromise between the first two: The patient education center could start relatively small and grow as

resources become available and the concept of a centralized patient education center gains the cooperation and the acceptance of the staff and the top management (gradual change).

Perhaps the most significant positive influence that could facilitate the successful establishment and operation of a patient education center would be the continued support of top management. As mentioned earlier, the establishment of a patient education center is one of the commander's personal objectives. For the most part, staff members who have been approached for their opinion as to what the hospital should do with reference to patient education have responded favorably with candid comments. Many of these same individuals have assisted in the random surveying of their patients.

The individuals who voluntarily formed a subcommittee of the CHEP for the express purpose of "getting the patient education center off the ground" are a measure of the sincerity and the depth of support the current staff will give a functional patient education center. The ability to purchase state-of-the-art equipment has the potential of being a motivator to those involved in the establishment of a patient education center. Once a center is established, modern state-of-the-art equipment is expected to have a positive influence upon the users (practitioner and patient).

The environmental factors indigenous to this area may provide a subtle, positive influence. The U.S. Army Community Hospital does, as advertised, serve a remote area. As such, the population within the catchment area is more reachable than the population of, perhaps, an urban area. The effect of the relatively "closed society" that is

assigned to Ft. Polk as well as the availability of the personnel in the housing areas through a post-operated channel on the local closed-circuit (cable) television renders the post population a captive audience. The post-run channel is an excellent vehicle for continuing community education. Programs could be viewed by the patient in the clinic areas while he/she waits for an appointment or viewed by the post housing resident as an alternative to the daily game shows and soap operas.

All potential influences may not be positive. Historically, patient education in this health care treatment facility has been effected by the traditional mode as opposed to a systems approach associated with a patient education center. Individuals can and often do react negatively to change. If there is adequate planning to include the education of the staff on the potential of a well-run patient education center, the negative reaction to change should be minimal. Another historical factor which is related to the traditional methodology of patient education is the mental orientation of the staff. As a non-teaching hospital, individuals among the staff may not be oriented to or accepting of an organizationally separate entity whose purpose is providing "the same" patient education which they have been traditionally offering. Through the routine course of permanent changes of station, resignations, and retirements, those elements of the staff that are positively inclined toward a patient education center could be elsewhere by the time the new hospital is opened and the patient education center in the new hospital has a chance to be successful.

Literature Review

Patient education is established as a national health priority. Two of the stronger indicators in support of that contention are the 1973 Report of the President's Committee on Health Education⁶ and the 1974 National Health Planning and Resources Development Act (P.L. 93-641).⁷ While Public Law 93-641 lists patient education as a national health priority, it is the last of the ten listed priorities. In an era of declining resources and spiraling inflation, one cannot expect patient education to be unquestionably funded. It must compete with higher national priorities which are traditionally acute care oriented.

There are civilian and military hospitals that have developed and currently fund successful patient education programs. While some hospitals, such as Lenox Hill Hospital in New York City, have published reports of their successes,⁸ local civilian hospitals such as Moss General Hospital in Lake Charles, Louisiana, have quietly established successful programs.⁹ An example of the systematic approach of a patient education center in a military hospital is the system designed by Kucha at the U.S. Army Medical Department Activity (MEDDAC), Ft. Belvoir.¹⁰ Another military hospital that utilizes Kucha's system is the 2nd General Hospital, Landstuhl, Germany.¹¹ Kucha concludes that the systematic approach vis-à-vis a patient education center is successful in improving the patient's knowledge above the level obtainable by the traditional method. Kucha adds the caveat that, even with the ability to increase the patient's knowledge, success of a patient education program depends upon adequate planning and design and acceptance by the staff. Kucha further concludes that education of the patient alone is

not enough. A total program should include the education of the general population of the community as well as the education of the staff.¹²

The American Hospital Association (AHA) concludes that, as an integral part of total patient care, patient education must be multidisciplinary. This is reflected in its recommendations as to the qualifications and the role of the coordinator. When evaluating an individual for the position of coordinator, the AHA recommends consideration be given to work experience, educational background, management skills, and beliefs or self-interests that indicate the individual is more interested in coordinating and managing patients than in providing patient teaching services. With such an individual, there is no question of the physician retaining control of a patient's treatment regimen (patient education). The position of a patient education coordinator is, as designed, an extension of the individual physician. For the position, the AHA recommends hospitals consider graduates of nursing, adult education, public health, and/or health education programs. Dependent upon the philosophy of the hospital management team, the patient education department can be oriented as a nursing department, an education department, or an administrative department.¹³

The AHA stresses the need to gain the cooperation and the support of the staff. As with Kucha, the AHA stresses adequate planning in the establishment of a program. Gaining the cooperation and the support of the staff is paramount if success is to be expected. The AHA provides an excellent overview as to why an institution should develop a patient education program (Appendix B). In addition to benefits to the patient, the AHA identifies benefits to the institution in

the accreditation process (planned patient education programs meet JCAH criteria), on health care legal issues (such programs assist in meeting criteria for informed consent as well as protection against subsequent liability), on professional responsibilities (such programs assist the professional in his/her total patient responsibilities), and on the management process (such programs effect more effective and more efficient utilization of resources).¹⁴ The literature concludes that patient education programs are a worthwhile adventure.

Methodology

Two basic information-gathering techniques were used to develop a data base to be used in evaluating the alternatives. First, the professional staff, the patients, and the potential patients (the community) were surveyed as to their opinions on patient education (appendices C-E). These three surveys were originally developed by Kucha as part of her Patient and Community Health Education Model study.¹⁵ Second, a records audit was made. Other information-gathering techniques included staff interviews and literature review.

In order to understand the current situation as it relates to patient education at this USACH, the above-referenced data base was analyzed to determine what patient education is currently being practiced, the methods being used in providing that patient education, and the frequency of patient education. Further analysis of the patient education requirements included the staff's identification of patient education areas at this USACH which are being administered on a recurring basis and those areas which have been identified as necessary but are not being performed.

Footnotes

¹R. W. Jampus, "The Practicing Physician and Patient Education," Hospital Practice, October, 1975, pp. 93-99.

²U.S., Department of the Army, Health Services Command, Patient and Community Health Education Model (PACOMED), by Delores H. Kucha, HSCD Report No. 79-001-A through E, Subreport E: A Patient Learning Center for an Army MEDDAC--A Feasibility Survey (Ft. Sam Houston, Tex.: Health Services Command, December, 1977), p. vi. Separate subreports hereinafter referred to as: Kucha, HSCD Report No. 79-001-__.

³Thomas A. Janke, Associate Professor, "Social Policy and Health Care Legislation," lecture delivered before class, U.S. Army-Baylor University Graduate Program in Health Care Administration, Academy of Health Sciences, Ft. Sam Houston, Texas, October 4, 1978.

⁴Kucha, HSCD Report No. 79-001-A through E.

⁵Letter, Joint Commission on Accreditation of Hospitals, Subject: "Report of Accreditation Survey," dated April 25, 1980, to Commander, U.S. Army Community Hospital, Ft. Polk, Louisiana, Hospital Care Sponsored Ambulatory Care Finding No. 1.

⁶U.S., Department of Health, Education, and Welfare, The Report of the President's Committee on Health Education (Washington, D.C.: Government Printing Office, 1973), pp. 11-12.

⁷Janke, op. cit.

⁸Lennox Hill Hospital, Health Education Center, A Report on 1978--Program and Activities (New York: By Author, 1979).

⁹Interview with Captain Paul Nelson, MC, Family Practice, U.S. Army Community Hospital, Ft. Polk, Louisiana, March 26, 1980.

¹⁰Kucha, HSCD Report No. 79-001-A through E.

¹¹Letter, Captain Kathleen Srsic-Stoehr, ANC, Patient Education Coordinator, Landstuhl Army Regional Medical Center, Subject: "Patient Education Center," dated May 13, 1980.

¹²Kucha, HSCD Report No. 79-001-A through E.

¹³American Hospital Association, Implementing a Patient Education Center (Chicago: American Hospital Association, n.d.).

¹⁴Ibid.

¹⁵Kucha, HSCD Report No. 79-001-A, pp. 25-43.

CHAPTER II

DISCUSSION

Current Situation

As currently practiced at this USACH, patient education is taught in the traditional mode. That is, it is decentralized to the individual physician and nurse who interact with the patient during the treatment regimen prescribed by the attending physician. As such, patient education in this treatment facility is dependent upon the initiative of that individual physician and/or nurse. This independence results in miniature patient education programs whose development and utilization have not benefited from the experiences, to include mistakes, of others. In formulation and application of patient education in this USACH, efficient and economic utilization of resources has not been an integral part of the decision process. As long as resources exist within the treatment setting, the interested practitioners will provide what patient education they perceive to be necessary. No one individual is responsible for program review (content) and resource utilization (format).

Data Base

In the development of a valid, relevant data base, information was gleaned from several sources. The professional staff, the patients, and the potential patients (the community) were surveyed for their professional and, as appropriate, personal opinions as to the future

direction of patient education in this USACH catchment area. In addition to the surveys, several members of the staff were interviewed. Random medical records were audited to determine the extent to which, if any, patient education was being documented.

The professional staff's reception to the problem-solving project and the survey process was positive. Of the thirty-five staff physicians, twenty-seven were surveyed. The criterion for selection was whether or not the physician interacted with patients on a daily basis in a setting that was conducive to patient education. Those who were not surveyed were limited to the commander, the chief of Professional Services, the pathologists, and any physician who was on leave or otherwise not available during the survey process. Of the twenty-seven surveyed, seventeen responded (63 percent). The criterion for selection of the nurses to be surveyed was that the individual was either a head nurse of a clinic or a ward or a nurse practitioner assigned to this facility who functions as a nurse practitioner. There are no nurse clinicians authorized or assigned to this USACH. Of the twenty-six nurses surveyed, twenty-six responded (100 percent). There were two additional nurses whose unsolicited responses were included.

As reflected in a recapitulation of the staff's responses (Appendix C), the staff's perceptions vary. When asked what types of patient education are currently being administered in this facility, responses covered the spectrum of medical care currently available at this facility. It was interesting to note that many of the areas identified as being performed were also identified as areas that are necessary but for which there is not enough time to discuss with the patient.

This type of response is not atypical for a staff which operates in a decentralized mode. Physicians and nurses who have the time, the resources, and/or the initiative are apparently able to address the educational portion of the patient's treatment regimen. Those who do not have the time and/or the resources apparently do not address patient education to the extent they have indicated they or someone else should. The staff's feedback was relatively universal in that a common response was that the staff is able to concentrate its educational efforts in a few select areas. However, the areas of concentration varied from individual to individual and from area to area. The similarity between what is being and what cannot be done is seen as a function of the decentralized approach: no system to follow, no sharing of resources, no program review.

With respect to the current patient education methods being used, the overwhelming majority of the staff indicated that they utilize individual (76 percent) as well as group settings (70 percent). While the most predominant teaching aid was listed as printed material, a significant portion of the staff expressed the desire to incorporate videotapes into patient education (44 percent). While some of the current printed material has been generated from in-house resources, most of it is of the variety provided by drug companies. The staff's response as to the disease and injury areas which are in the greatest need of patient education programs was similar to the response received by Kucha in her survey at Ft. Belvoir, Virginia.¹ The similarity of responses could be a function of the similarity of the staff's educational background, the health care delivery system in which the staffs operate

(military), and a similarity in the patient populations they serve (young military families).

If staff cooperation and support are to be nurtured through a developmental phase toward a patient education center, it would be reasonable to concentrate one's initial efforts and resources in the areas which the staff has identified as critical. Diabetes and hypertension were by far the most popular staff responses. This could be a result of several factors. First, the staff can readily identify diabetes and hypertension as two areas where patient education can have a measurably positive influence upon the patient's management of his/her disease. Second, the previously mentioned voluntary committee could have influenced the staff. Its development of programs in diabetes and hypertension has been discussed with the staff as individuals and in group settings.

The staff's responses underscore the need to gain its acceptance of the patient education center concept if that concept is to be a viable option to the physician when he/she considers the education of the patient. Only 5 percent of the staff indicated a need for a patient education center and/or more physical space. While virtually all of the staff interviewed espoused a desire to improve the quality of patient education available to patients, most staff members would rather retain control of their patients than refer them to an outside activity. At present, only 9 percent of the staff refers patients outside the clinic/ward for education. The acceptance of the patient education center concept will not come by decree. For the staff to accept the patient education center concept, the members must believe that the

center will benefit their own clinic/ward operation as well as their patients. Gaining support and cooperation of the staff will be the most crucial as well as the most difficult task of the patient education center coordinator.

For the consumer survey (Appendix D), patients were randomly selected from each patient treatment area within the hospital (all clinics, wards, troop medical clinics, etc.). The number of patients surveyed per treatment area was dependent upon that treatment area's share of the average daily workload. For the purpose of this survey, patient workload corresponded to the number of patient encounters per day per treatment area (one outpatient visit equaled one inpatient). The surveyed patients were selected from among the patients the ward or clinic encountered the day of that ward's/clinic's survey. The selection criterion utilized was the matching of the patient's Social Security number to a preselected set of random numbers. The patients were surveyed within the clinic/ward setting during the patient's "free time" (i.e., while waiting for a clinic appointment). The time to complete the survey was not a factor with the consumer survey. Of the 200 patients surveyed, 200 responded (see Table 1).

While the patient's preference for the physician is understandable (42 percent), the relatively high acceptance of a health educator (34 percent) is significant if one is to pursue the patient education center concept. The unsolicited comments relative to whether or not the physician or the nurse gives the patient adequate information highlights the potential of the presenter's style and/or personality to influence the patient's perception as to the value of the education.

TABLE 1

PATIENT DEMOGRAPHIC PROFILE, PATIENT
EDUCATION CONSUMER SURVEY

Category	Percent of Patient Population
Age:	
Under 40 years old	73
Sex:	
Female	53
Race:	
White	59
Black	30
Sponsor:	
Active Duty	73
Enlisted Man	64
Officer	9
Retired	20
Patient:	
Spouse	48
Sponsor	46
Other Dependent	11
Patient's Occupation:	
Housewife	31
Combat Related	24
Formal Education:	
High School or Less	69
Marital Status:	
Married	68
Children	60
Patient/Health Education Format:	
Via Combination of Media	39
Via Television	22
Via the Physician	42
Via a Health Educator	34
Via a Nurse	29
Group Lecture/Class	64
Daytime	65
With Family Present	81

The acceptance of the patient educator does not appear to be solely oriented to the educator's profession. Based upon the consumer survey, the educator's title is expected to have an influence upon the patient during the patient-educator initial encounter. However, the patient's

acceptance of the patient education content will be a function of more than the patient's acceptance of the educator's title. Influencing factors will include the educator's professionalism, the format of the presentation, and the educator's personality. With the variety of patient populations in the USACH's catchment area, a single patient education protocol or format may not be capable of addressing all educational levels adequately. The knowledge levels and the attention spans of the different educational, age, and sociocultural groups are expected to vary. Patient education protocols must be flexible in order to address all types of patients.

With respect to areas where patient education could benefit the patient, the areas of concern or worry to the patient are similar to the concerns of the staff. The patients' interest in family-oriented community education reflects their perceived needs (common childhood illnesses, growth and development, effect of lifestyle upon the family, etc.). If a patient education center is selected as the optimal feasible solution, the family-oriented areas, as well as those of cancer, heart disease, diabetes, and hypertension, should be among the first programs developed.

The survey of the potential patients (the community) was not successful. The comments as presented in Appendix E do not reflect a statistically defensible sample population. Several factors are perceived to have contributed to the sampling difficulties. First, the design of the questionnaire is believed to have been too long and too complicated for the random voluntary responses desired. When Kucha developed her questionnaire, she and her permanently assigned assistants

took two years to complete the entire Patient and Community Health Education Model. The typical individual that was approached for this USACH's survey did not wish to participate in any survey. Once a "volunteer" was into the survey process, he/she often expressed confusion and lack of understanding to the seemingly basic questions. As such, the average survey time was over ten minutes per person. The surveyors expressed concern over the attention span of those surveyed and, thus, the validity of their answers. If this or any other researcher is to use Kucha's or any other study as the basis for a patient education survey, it is strongly recommended that the patient and the community questionnaires be rewritten. A researcher should seek only that information which is considered absolutely essential for the success of the project. Second, the questionnaire format must be easily understandable to those participating in the survey. For example, a more appropriate format could include multiple choice for objective areas and a Lickert scale for subjective areas. Even though the validity of the responses is questionable, they are presented as a matter of interest (Appendix E).

In an attempt to gain an understanding as to the extent to which patient education is being documented and whether or not the patient understands the health education he/she receives, two sets of medical records were audited (Appendix F). The first set of records was a random sample of current outpatient charts. Out of thirty charts, only eight (26.7 percent) documented the presentation of patient education. Of those eight documented presentations, only one chart documented any patient understanding (i.e., "The patient verbalizes an understanding of"). The staff's opinion is that the actual incidence of

patient education and the patient's understanding of that education is higher than indicated by the audit. This is substantiated by the nurse surveyor in her finding in the recent JCAH accreditation survey that the staff does not adequately document patient education.²

Recognizing the variety of nonemergency treatment sessions reflected in the outpatient records audit, a random selection of diabetes mellitus cases was chosen for audit. The purpose of choosing diabetes mellitus cases was twofold: First, the staff has expressed through interviews that diabetes is a prime example of where patient education can improve the patient's understanding of his/her disease and, thus, the management of his/her daily care; second, diabetes is the patient education area which the voluntary committee chose as its first prototype. The audit showed that over 96 percent of the inpatient diabetes cases received some form of patient education. However, only 20 percent of the diabetic patients who received patient education have it documented in their medical records that they verbalized their understanding of the patient education they received. Considering the need to gain the staff's support and cooperation, the choice of diabetes mellitus as a prototype appears to have been validated.

Workload

The records audit described above highlights the difficulty in an objective attempt to determine or predict the patient education workload. In interviews, the staff indicated the amount of time and resources to be committed varies among specialty areas. For example, in the ophthalmology and optometry area, the staff indicated that a patient

education program would be of little value. In other areas, the nursing staff's subjective and perhaps biased predictions as to the amount of time the nurse spends in patient education ranged from 20 to 75 percent. Kucha predicated her study upon the nurse clinician spending approximately 40 percent of his/her time in patient education.³ However, in the cost/benefit analysis of her study, it was recommended that the time the staff spent in patient education be validated.⁴

Based upon staff interviews, the current personnel would refer from 80 to 100 patients per day (approximately 10 to 25 percent of the patient encounters per day in the treatment setting) to a patient education center. The range of referrals would be a function of the programs available and the level of the staff's acceptance.

Organizational Structure

The current trend is toward a patient education center that utilizes a systems orientation in the education of the patient. Developing systems that appear successful⁵ have centralized the management responsibilities of the patient education center with a patient education coordinator. In such programs, specialists within the hospital are responsible for the development and the review of the program content. With physical space at a premium in the new hospital, those patient education areas which are susceptible to large group lectures (i.e., prenatal care, well-baby clinic, etc.) may have to remain within the clinic setting. The scheduling for the larger, recurring group presentations would be dependent upon the preplanned availability of conference and/or classroom areas.

Considering the influence of the U.S. Army nurse in patient education, it would be an acceptable alternative to orient a patient education center as a nursing function. Such a department or office could come under the supervision of the Nursing and Training Division. However, if the position of education coordinator within the MEDDAC becomes a full-time position, such an individual could assume responsibility for all education and training within the MEDDAC. In addition to patient education, the individual in the educational coordinator's position could be responsible for continuing medical education as well as other staff training (to include military). The degree of centralization and the orientation of the patient education center will be dependent upon the desires of the commander and the acceptance of the staff.

Manpower

Objective predictions as to manpower requirements become difficult without documentable workload predictions. The literature and the program at the Landstuhl Army Regional Medical Center indicate a three-person manpower requirement for a medium-sized hospital-based patient education program: two patient education coordinators with the necessary secretarial support.⁶ If one accepts Kucha's contention that approximately 40 percent of a nurse clinician's time is spent in patient education,⁷ one could extend that as the basis to calculate the gross manpower savings of a patient education center. An extension of the nurse clinician's involvement would be that the clinic/ward nurse who assumes primary responsibility for the patient education within his/her clinic/ward area would spend approximately 40 percent of his/her time

in patient education. With few modifications, the staff supports the 40 percent hypothesis. It is understood that, under patient education (centralized or decentralized), the individual staff members will continue to provide some level of patient education. With 40 percent of one individual's time being equivalent to a .4 man-year, the initial gross calculations of manpower savings suggest the need for serious consideration of the patient education center concept (see Table 2). For the purpose of this calculation, the secretarial requirement is not included. If a patient education center becomes a reality in the new facility, secretarial support is expected to be provided by centrally located personnel who serve several co-located activities.

TABLE 2

MANPOWER SAVINGS

Treatment/Specialty	Manpower Requirement (In Man-Years)
Medicine . . . . .	.4
Surgery	
General . . . . .	.2
Orthopedics . . . . .	.2
OB/GYN . . . . .	.4
Pediatrics . . . . .	.4
Family Practice Service	
Clinic No. 1 . . . . .	.4
Clinic No. 2 . . . . .	.4
Troop Medical Clinics . . . . .	.4
Clinical Dietetics . . . . .	.4
Other Clinics . . . . .	.4
	<u>3.6</u>
Less Minimum Suggested Staff	<u>-2.0</u>
	2.4 Man-Year Savings

Equipment

Equipment requirements for a patient education center will vary

according to management's preference as to the types of equipment it believes to be the most efficient and the most effective. While Kucha suggests a program oriented toward the videotape cassette player, other programs prefer less expensive equipment. A problem which is perceived to be of real potential is the limiting of a program in its equipment and resources. When a program restricts itself to one type of audiovisual equipment, it has, in effect, confined itself as to the number and the types of program it can utilize from outside resources. For instance, if a program limits itself to only a videotape cassette player for its audiovisual assistance, the program is restricted to only those types of programs which are available on videotape cassettes. Not all video programs are available on videotape cassettes; some programs are available only on film strip players, some on 16mm film, etc. Due to the depth of the spectrum of medical care and, thus, patient education, patient education programs can be purchased or made in a variety of audiovisual formats.

If funding is available, a well-balanced program would provide the opportunity for the greatest variety of quality patient education. The use of a balanced program is supported by the staff's and the patients' responses in their respective surveys. Remembering the need to gain the support and the cooperation of the staff and the acceptance of the patients, a well-balanced audiovisual program would have an advantage over a program that is oriented toward a single type of audiovisual assistance.

A list of the specific audiovisual equipment requested/recommended by the patient education coordinator is attached as Appendix G.

For the purpose of this study, the audiovisual equipment listed is for informational purposes only. With the task of determining the audiovisual requirements (actual needs, brands, prices, etc.) being the responsibility of the patient education coordinator, any evaluation or decisions relative to that equipment should consider the patient education coordinator's evaluation of that equipment requirement. The patient education coordinator's decision process relative to the specific audiovisual requirements was not a part of nor an objective of this study. Office equipment will be a function of the physical space allocated. As such, the requirements will be addressed in the next section.

Physical Space

As with manpower and equipment, physical space requirements are difficult to predict in the absence of objective workload predictions. As such, an acceptable alternative is to modify, as required, that which has been successful for someone else. For a patient education center in the new hospital, Kucha's recommendation as to the physical space and the nonaudiovisual equipment would be adequate.⁸ However, interviews with the staff indicate their desire to modify Kucha's basic recommendation by adding a small room suitable for individual (private) counseling. A general diagram and equipment list (nonaudiovisual) are attached as Appendix H. The total footage requirement approximates 770 square feet (see Table 3).

Program Development

Whether one pursues a centralized or a decentralized approach

TABLE 3
PHYSICAL SPACE REQUIREMENTS

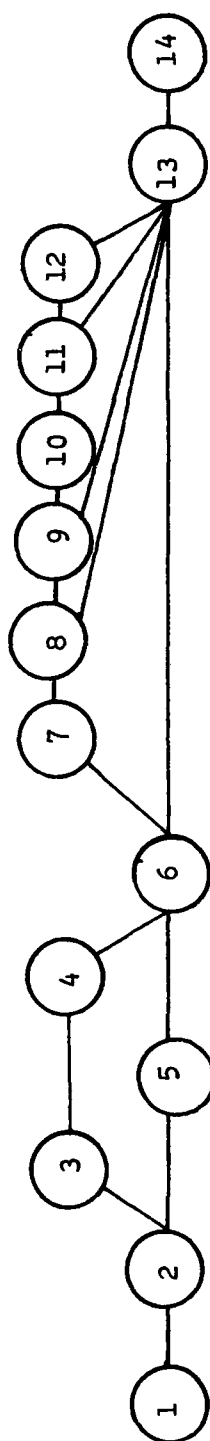
Room	Square Feet
Patient Education Center	450
Room for Individual Counseling	100
Storage	100
Office of Coordinator	<u>120</u>
TOTAL	770

to patient education, the development of the individual programs should, for the purpose of economy and efficiency, follow a systematic approach. A modification of the approach designed by Kucha⁹ is presented in Figure 1. The basis of such an approach is that one identifies the desired programs, defines the objectives and the measurement criteria, compares existing programs with in-house capabilities, and selects the best alternative.

As resources become available, programs should be developed or purchased according to a priority established by the patient education coordinator and the CHEP and approved by the commander. The involvement of the staff in the development of programs specific to members' specialty areas is expected to facilitate their acceptance of the patient education concept and, thus, of a patient education center. While the voluntary subcommittee of CHEP is expected to be effective, it is physically limited and cannot be expected to develop an entire program.

Staff and Community Education

As referenced earlier, two important aspects of a total patient



REQUIREMENT

1. Topic Selection
2. Task Analysis
3. Development of Objectives
4. Development of Criteria Measures
5. Evaluation of Existing Programs
6. Initial Comparison of Objectives versus Existing Programs
7. Design Instruction System
8. Evaluation of Designed System, Comparison with Existing Programs (As Necessary)
9. Design Protocol/Lesson Plan
10. Data Collection, As Necessary
11. Revision, As Necessary
12. Cost Analysis
13. Final Evaluation, Comparison with Existing Programs (As Necessary)
14. Program Implementation

PEC--Patient Education Coordinator
 CHEP--Community Health Educational Panel
 CDR--Commander

RESPONSIBILITY

PEC/CHEP/CDR (As Desired)
 PEC/CHEP/CDR (As Desired)
 As Designated
 As Designated
 As Designated
 PEC/CHEP/CDR
 PEC/CHEP
 PEC/CHEP
 PEC/CHEP
 PEC/CHEP
 PEC/CHEP
 Medical Staff/CDR
 PEC/CHEP

Fig. 1--Patient Education Program Development

education program include (1) education of the staff and (2) education of the community.¹⁰ In addition to their continuing medical education, inservices, etc., staff members must be kept abreast of the total program. This includes familiarity with the program contents and capabilities as well as familiarity with any protocol or lesson plan with which the staff is associated.

The individual members and the collective staff must be aware of and teach from an accepted/approved protocol or lesson plan. Without that assurance, the patient education effort will continue to be a collection of decentralized programs. Inefficient and uneconomical operation of such fragmented programs would drain resources which could be directed toward higher priority programs.

Community education can be as inventive as the patient education coordinator, the CHEP, and the commander wish it to be. Utilization of the post paper to publicize the available programs would be a minimum. A community education program does not have to be limited to an annual retiree's day. Virtually all types of media and marketing efforts can be explored in an effort to reach the community. Post paper, command letters, post television, and local radio could be utilized to publicize overall as well as specific parts of the patient education program. Community programs could provide scheduled, recurring disease-specific screenings. TELMED or a similar program could discuss selected topics. A coordinated community education effort could address a specific topic or program on a recurring basis. For instance, April could be cancer month; May, diabetes month; June, hypertension month, etc. The topics which are addressed in the media should include the areas the patients

as well as the medical staff wish to be addressed. The staff's and the patients' responses to their respective questionnaires address multiple areas of concern.

Alternatives

The criteria used to compare and contrast the alternatives are, for the most part, oriented toward the resources requirements of patient education: workload, the level or the amount of patient education the staff could be expected to accomplish under the system (alternative) in question; manpower, the staffing or personnel requirement for the system (alternative) in question; equipment, the audiovisual and the furniture requirements; and physical space, the square footage or room requirements. A fifth criterion used in the comparison is quality: a subjective evaluation of the system (alternative) in question or of individual patient education programs.

A simple comparison of the alternatives is presented in Figure 2. The criteria measurements use the current situation as a base. It must be stressed that the success of any one of the alternatives, to include the current situation, is totally dependent upon the acceptance, the support, and the cooperation of the staff.

The current situation (alternative one--no change) represents a misuse of resources. For instance, the staff has identified a major problem in that it cannot accomplish what it perceives as essential. Another example of misuse of resources is the development of similar patient education programs by the personnel of two or more clinics / wards. An example is the prenatal programs currently utilized in the

CRITERIA	* ALTERNATIVE ONE (No Change)		* ALTERNATIVE TWO (Immediate Change)		* ALTERNATIVE THREE (Gradual Change)	
	PRO	CON	PRO	CON	PRO	CON
Workload		Staff has identified inability to accomplish total patient education needs	Increase	Dependent upon staff's immediate acceptance	Increase	Dependent upon staff's gradual acceptance
Manpower		Staff expected to meet patient education requirement by increasing staff requirements and authorizations	Decrease, if staff accepts	Increase, if staff does not accept (staffing the patient education center)	Decrease	
Equipment		Staff expected to duplicate equipment in order to support fragmented programs	Minimal total cost (standard equipment, central location)		Minimal total cost (standard equipment, central location)	
Physical Space	Available in current facility	Not available in new facility	Available in current and/or new facility		Available in current and/or new facility	
Quality		No quality control mechanism	Protocols, quality control mechanism available	Dependent upon staff's acceptance	Protocols, quality control mechanism available	Dependent upon staff's gradual acceptance

* Success of any one alternative dependent upon staff acceptance, support and cooperation

Fig. 2--Comparison of Alternatives by Criteria

OB/GYN and the Family Practice clinics. Independent of one another, these particular clinics have formulated their programs and obtained their own resources (duplication of manpower and equipment). With respect to the content of the current patient education programs, the first alternative has not allowed for a quality control mechanism. Protocols have not been developed. There is no assurance that different educators present the same information to the patients. The individual program may or may not provide quality patient education. If it does, the fact is not documented. If it does not, the staff presenting the substandard patient education may or may not be aware of any deficiencies. If the staff is not aware, it cannot be expected to make the necessary changes to improve. Considering the deficiencies outlined above, the first alternative is not acceptable.

Initially, alternative two, an immediate change to a patient education center, may appear to be an economically wise move. It is true that, as with the third alternative (gradual change), the second alternative can economically utilize equipment, manpower, and physical space resources. However, the staff cannot immediately produce a total patient education system. If the establishment of a patient education system were to be immediate, there would have to be a wholesale purchase of existing programs. Besides being expensive, existing programs may or may not be adaptable to this USACH's patient education objectives. Without the opportunity to personalize its involvement, the staff may not readily accept outside programs. Immediate change runs a high risk of staff resistance. There are several psychological roadblocks to change: need for familiarity, need for order, need for minimum risk,

and need to conform.¹¹ Immediate change may not allow the staff the opportunity to be flexible; therefore, it may not adapt to new requirements. Considering the potential problems with the staff accepting immediate change, the second alternative is not acceptable.

As with the alternative outlined above, alternative three (gradual change) can economically utilize equipment, manpower, and physical space resources. The difference between alternatives two and three is that the progress of the third alternative would parallel the staff's acceptance of the program. Under this alternative, resources (other than the initial investment in physical space) would not be expended without the necessary staff acceptance. As with the second alternative, a quality control measure (protocols) is a mandatory part of the third alternative. If protocols were developed and used, they would be the mechanism to insure that different staff members provided the same patient education every time it was presented. Considering the advantages of predicating the progress of a patient education system around the staff's acceptance, support, and cooperation, the third alternative is the best choice.

Footnotes

¹Kucha, HSCD Report No. 79-001-A.

²Letter, JCAH, op. cit.

³Kucha, HSCD Report No. 79-001-E, p. ii.

⁴Ibid., p. 3.

⁵Letter, Srsic-Stoehler, op. cit.

⁶Ibid.

⁷Kucha, HSCD Report No. 79-001-E, p. 3.

⁸Kucha, HSCD Report No. 79-001-D, pp. 141-56.

⁹Kucha, HSCD Report No. 79-001-B, p. 3.

¹⁰Kucha, Prodromus.

¹¹Jay Hardman, Assistant Professor, "The Health Care Administrator's Role as a Change Agent," lecture delivered before class, U.S. Army-Baylor University Graduate Program in Health Administration, Academy of Health Sciences, Ft. Sam Houston, Texas, January 18, 1979.

CHAPTER III

CONCLUSIONS

Patient education in this U.S. Army Community Hospital has been traditionally decentralized. The success or failure of patient education has rested upon the individual initiative of the physician and the nurse. With a fragmented system, the efficiency of the education presented and the economy of the resources necessary to present that education have not been an integral part of the decision process with regard to the development of patient education programs.

A review of the literature established a trend toward the patient education center. Acceptance of change in the patients' treatment regimens is not expected to be immediate if the staff sees such a change as a threat to itself or the patients. In the development of a patient education program, the attending physician needs to be reassured that he will retain control of the patient and that the education given will be that which is prescribed by the physician. Gaining the support and the cooperation of the staff is seen as the critical factor in the establishment of a patient education center.

The objective documentation of workload normally required before the expenditure of resources in the support of a self-generated mission was missing. The analysis contained within this paper is, for the most part, the subjective evaluation of this researcher and the staff. In the absence of fact, decisions must be made based upon logical deductions from that information which is available.

A planned, well-organized patient education center that utilizes a systems approach will benefit the hospital, the staff, and the patients. A systems approach to patient education will improve the patients' level of learning with respect to the patients' basic knowledge of disease or injury and the management of that health problem.

CHAPTER IV

RECOMMENDATIONS

If the information presented in this problem-solving project is to be referenced in the development of a patient education center for another hospital or if a cost/benefit analysis of a patient education center at this USACH is pursued, it is recommended that:

1. The validity of the assumption that the staff of the average clinic/ward spends an equivalent of .4 man-year in patient education be established.
2. The consumer and the community questionnaires be redesigned to request only essential information in an easy-to-understand format.

With respect to patient education at the USACH, it is recommended that the commander approve the development of a total patient education system, i.e., patient education center, staff, and community education. It is further recommended that such a program be initiated immediately with a completion date to correspond to the occupancy of the new hospital (scheduled for October, 1982). Other specific recommendations include:

1. Establishment of a priority listing of patient education programs to be purchased or developed.
2. Review of existing programs which are compatible with this USACH's objectives and are available.
3. Acquisition of staff support and cooperation through personal involvement.

4. Selection, coordination, and development of task topics by specialty or hospital area.
5. Development of individual patient education programs via a systems approach.
6. Formulation of protocols/lesson plans for all USACH, Ft. Polk, patient education.
7. Inclusion of physical space and equipment requirements (Appendix H) for a patient education center in the outpatient area of the new hospital (i.e., design changes, etc.).
8. Purchase of audiovisual equipment after review and approval of the patient education coordinator's recommendations (Appendix G).
9. Development of staff education programs to include information briefs as to the purpose and the capabilities of the patient education center.
10. Formulation/purchase of community education programs as outlined in the Discussion (i.e., calendar of programs, TELMED, etc.).

APPENDIX A

DEFINITIONS

DEFINITIONS

Community Education - Dissemination of health and preventive medicine information to the population served and the persuasion of that population to seek specific education they need to regain or maintain a healthy state.

Organizational Structure (formal) - Lines of responsibility that define roles and functions of those personnel involved in the education of the patient, the community and the staff.

Patient Education - Any activity planned for the purpose of improving an individual patient or group of patients' knowledge and/or behavior, with the goal of regaining or maintaining a healthy state.

Patient Education Center - The organizational structure through which patient education is accomplished.

Patient Workload - Number of equivalent patient encounters per day (clinic visit = one work unit = one inpatient).

Staff Education/Training - Health education of the staff that includes their multidisciplinary role in the education of the patient and the community as well as the maintenance of their professional skills.

APPENDIX B

WHY DEVELOP A PLANNED PATIENT EDUCATION PROGRAM

WHY DEVELOP A PLANNED PATIENT EDUCATION PROGRAM

PERSPECTIVEREASONS

Accreditation

Planned patient education programs provide a means to meet the patient education criterion outlined by the Joint Commission on Accreditation of Hospitals.

Legal

Planned patient education programs provide a means for helping to meet the health care institution's criteria for informed consent and helping to protect the institution from subsequent liability.

Professional

Planned patient education programs assist the health care professional in meeting his responsibility for providing patient education as an integral part of care, as defined in professional practice acts.

Management

Planned patient education programs help the institution use its limited resources of staff, equipment, space, and, especially, dollars more efficiently.

Planned patient education programs can result in more effective health care service, specifically accomplishing (see bibliography):

Determination of essential information for patients.

Assurance of consistency of information to patients and their families.

Inclusion of appropriate members of the health care team in determining and carrying out educational objectives.

Clarification of educational experiences that physicians can rely on for their patients.

Total hospital

Planned patient education programs can result in:

Improved care.

Better utilization of hospital resources.

Fewer readmissions to inpatient facilities and shorter lengths of stay.

Why Develop a Planned Patient Education Program (Continued)

PERSPECTIVEREASONS

Community support for the hospital.

Increased staff communication and satisfaction.

Patients

Planned patient education programs offer a means to obtain information that can better equip patients to make decisions and carry out behaviors that safeguard their well-being and permit them to meet their own health care needs.

Planned patient education programs help ensure that the patient receives correct, nonconflicting information from each staff person involved, that is, the patient experiences continuity of the educational component of care.

Planned patient education programs provide a means to meet the educational needs of patients included in A Patient's Bill of Rights.

SOURCE: Implementing Patient Education in the Hospital, American Hospital Association, Chicago, Illinois, 1979, p 41-2

APPENDIX C

PROFESSIONAL STAFF ASSESSMENT

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is The Adjutant General's Office.

REFERENCE OR OFFICE SYMBOL

AFZX-MED-XO

SUBJECT

Professional Staff Assessment Patient Education Center,
US Army Community Hospital, Fort Polk, LA 71459

TO

FROM

Admin Resident

DATE

CMT 1

MAJ Williams/jr/2272

1. Please complete and return CMT 2 to the undersigned.
2. The purpose for gathering this information is to provide a base line as to the professional staff's assessment of patient education as it is being practiced and how you feel it should be practiced. The utilization of this information will be oriented toward the current facility as well as the new facility. The Community Health Education Program (CHEP) Committee and MAJ Linda Scott are currently directing their energies toward the development of a patient education center to be utilized today within the current hospital complex. The initial site for this center is in the Outpatient Clinic. As for the development of individual patient and community education programs, several individuals are donating a significant portion of their own time to assist MAJ Scott. Their efforts can only be assisted by the information you provide.
3. With respect to the new facility, a patient education center or area was not included in the original design. If your responses indicate the need for such an area, design changes will be requested.
4. The results of your assessment and a patient questionnaire will be available upon request. Please direct any questions to any of the individuals listed below:

Dr. Paul Nelsen, Family Practice Clinic #1, Bldg. 516, Ext 2814

MAJ Linda Scott, R.N., Outpatient Clinic, Bldg. 733, Ext 7083

MAJ John A. Williams II, MSC, Admin Resident, Bldg 734, Ext 2272

JOHN A. WILLIAMS II
Major, MSC
Administrative Resident

AFZX-MED-

SUBJECT: Professional Staff Assessment Patient Education Center, US Army
Community Hospital, Fort Polk, LA 71459

TO MAJ Williams
Admin Resident

FROM

DATE

CMT 2

1. Types of patient education being done:

2. Methods used:

3. Identify the areas of repetition in patient education.

4. Types of patient education (information and management) identified, but do not have time to discuss with patients.

AFZX-MED-

SUBJECT: Professional Staff Assessment Patient Education Center, US Army
Community Hospital, Fort Polk, LA 71459

5. Are there any resources (Human or Technological) you would like to have assist you in this area?

6. Name two patient education areas that are of greatest need in the following categories:

Chronic medical conditions

Selected middle management problems in OB/GYN, Pediatrics, Surgery

Acute minor illnesses

Community Health

PROFESSIONAL STAFF ASSESSMENT
PATIENT EDUCATION
US ARMY COMMUNITY HOSPITAL, FORT POLK, LA

TYPES OF PATIENT EDUCATION BEING DONE:

In-Patient Teaching

General Categories

Acute Minor Illnesses

Common Illnesses

Medical (medications, diet, etc)

Diabetes Mellitus

Hypertension

Cardiac Rehabilitation

Asthma

Chronic Disease (disease specific)

Hepatitis

Neuro Muscular Disorders

GI/Ulcer

Pediatrics

Diabetes Mellitus

Hypertension

Asthma

Chronic Disease (disease specific)

Hepatitis

Neuro Muscular Disorders

GI/Ulcer

Immunizations

Surgical (medications, diet)

Pre-op Teaching

Surgical Procedures (procedure specific)

Head Injuries

Breast Exam

Orthopedic

Care of Sprains

Cast Care

Exercise to Increase Joint Range (physical therapy)

Crutch Walking (physical therapy)

Speech Therapy (occupational therapy)

Explanation of learning disability (occupational
therapy)

OB/GYN (medications, diet)

Routine Mother/Baby Care

Prenatal Classes

Postpartum Classes

Birth Control Counseling

Self Breast Exam

Ambulatory Care, Non-Emergency

General Categories

Acute Minor Illnesses

Common Illnesses

Medical (medications, diet)

Diabetes Mellitus

Hypertension

Obesity

Cardiac Rehabilitation

Chronic Disease (specific)

Asthma

GI/Ulcer

Immunizations

Arthritis

Chemotherapy

Pediatrics

Immunizations

Well Baby Development

Newborn Care

Child Care

Surgical (medications, diet)

Breast Exams

Pre-op Counseling

Post-op Counseling

Orthopedics

Care of Sprains

Cast Care

Exercise to Increase Joint Range (PT)

Crutch Walking (PT)

Speech Therapy (OT)

Explanation of Learning Disability (OT)

OB/GYN (medications, diet)

Prenatal Classes

Mother/Baby Classes

Birth Control Counseling/Diaphragm Fittings

Planned Parenthood

Self Breast Exam

Dietary Service

Disease Specific

Obesity

Psychiatric

Behavioral Problems

Psycho-Social Problems

Management of Stress

<u>CURRENT METHODS USED</u>	<u>% OF RESPONSES</u>
Individual Counseling/Instruction	76%
Group Counseling/Lecture	70%
Printed Materials	63%
Audio Visual Aids (slides, flip charts, models, etc)	37%
Referral to Outside Clinics	9%

<u>RESOURCE ASSISTANCE</u>	<u>% OF RESPONSES</u>
Videotapes	44%
Printed Materials	25%
Models	2%
Additional Personnel (i.e., clerical, nursing, patient education counselor, etc)	23%
Addition Space (i.e., patient education center)	5%

CURRENT AREAS OF REPETITION

General

Medication Administration

Immunizations

Medical

Diabetes

Headaches

Hypertension

INH Prophylaxis

Low Back Pain

Weight Loss

Pediatrics

Routine Mother/Baby Care

Well Baby Development

Surgical

Post-op

Orthopedics

Crutch Walking

Care of Sprains

OB/GYN

Vaginitis

Prenatal

Birth Control

Clinical Dietetics

Disease Specific Counseling

Infant Nutrition

PATIENT EDUCATION IDENTIFIED,
BUT DO NOT HAVE ENOUGH TIME TO DISCUSS WITH PATIENTS

GENERAL

Coping with adolescents	Pre-marital counseling
Medication administration	Sex counseling
Common illnesses/diseases	Alcohol abuse
Changing life style	

MEDICAL

Arthritis	Allergies
Diabetes	Hypertension
High blood pressure	Venereal disease
Cancer	Heat/cold injuries
Cardiac rehabilitation	

PEDIATRICS

Newborn care
Child care

SURGICAL

Pre-operation/post-operation counseling

ORTHOPEDICS

Case care

OB/GYN

Birth Control	Lamaze classes
Parentry	Prenatal
Menopause	Breast exam
Feeding techniques	

DIETARY

Obesity
Infant nutrition

PSYCHIATRIC/SOCIAL SERVICES

Management of stress
Child abuse
Psycho-social problems

WHERE THE PRIORITY IS NEEDED

CHRONIC MEDICAL CONDITIONS

Diabetes
Hypertension
Dietary Counseling
Heart Disease

SELECTED MIDDLE MANAGEMENT

Self Breast Exam
Pre-operation/post-operation Counseling
Pre-natal/post-natal Exercise

ACUTE MINOR ILLNESS

Upper Respiratory Infection
Urinary Tract Infections
Fever in Children
Common Illnesses, Sprains, Strains

COMMUNITY HEALTH

Communicable Diseases
Immunizations
Parenting
Accident Prevention
Poison Control

APPENDIX D

CONSUMER QUESTIONNAIRE ON PATIENT EDUCATION

CONSUMER QUESTIONNAIRE
PATIENT EDUCATION
U. S. ARMY COMMUNITY HOSPITAL
Fort Polk, Louisiana 71459

INSTRUCTIONS: Please answer each item by supplying the correct information;
if you have questions, do not hesitate to ask the monitor;
the numbers on the extreme left are for coding purposes.

1. Date: _____
2. Patient's name: _____
3. Date of birth: _____
4. Social Security Number: _____
5. Race or ethnicity: _____
6. Sex: _____
7. Military Status of sponsor: ☐ AD ☐ Retired ☐ Deceased ☐ Other
☐ Officer ☐ Officer
☐ EM ☐ EM
8. Patient's relationship to sponsor: ☐ Sponsor ☐ Spouse ☐ Dependent
9. Occupation:
 - 0 - None (unemployed or retired)
 - 1 - Housewife
 - 2 - Administrative (desk work)
 - 3 - Technical specialist (mechanic, computers)
 4. Professional other than medical (lawyer, clergy)
 - 5 - Combat related (unit groups)
 - 6 - Student (full time)
 - 7 - Blue Collar (custodian, maid, janitor)
 - 8 - Medics (RN, MD, PN, DDS, ets.)
 - 9 - Other

Consumer Questionnaire - Patient Education (Cont'd)

10. Marital Status: Married _____ Engaged _____
Widowed _____ Divorced _____
Single _____ Separated _____
11. Education Completed:
Elementary School (1-6 grades) _____
Junior High School (7-8 grades) _____
High School (9-12 grades) _____
1 to 3 Years College _____
Baccalaureat Degree _____
Master's Degree _____
Doctor's Degree _____
12. Relationship of respondent to head of household: _____
13. Family size and composition: _____
14. Do you have any children? _____
15. What are their ages? _____
16. How would you like the patient and/or community health education presented?
Through what medium? Or combination of media?
Radio _____ Tape (audio) Cassette _____
TV _____ Booklet _____
Lecture _____ Combination _____
17. Who would you like to present the patient and/or community health education?
Medic _____ Health Educator _____
Nurse _____ Secretary _____
Physician _____

Consumer Questionnaire - Patient Education (Cont'd)

18. Would you prefer to have the information presented in groups or individually?
19. Would you be interested in having the information given during the day or evening?
20. Would you prefer to have the information given only to you or would you like the family to participate?
21. Do you feel the physicians give you adequate information about your illness in order that you can be an effective self-care agent?
22. Do you feel the nurses give you adequate information about your illness in order that you can be an effective self-care agent?
23. If people were informed, which illness(es) would they be concerned about? (Select one, all, none)
- Diabetes _____ Cancer _____
- Hypertension _____ Accidents, vehicle _____
- Heart Disease _____ Stomach ulcers _____
- Alcoholism _____ Emphysema & Bronchitis _____
- Other _____
24. Which illness or illnesses does the average person worry about fairly often? (all, some, none)
- Heart Disease _____ Diabetes _____ Cancer _____
- Pneumonia _____ Alcoholism _____ Leukemia _____
- High Blood Pressure _____ Emphysema & Bronchitis _____
- Other _____

Consumer Questionnaire - Patient Education (Cont'd)

25. Which illness or illnesses does the average person worry about rarely?

Heart Disease _____ Diabetes _____
 Cancer _____ Pneumonia _____
 Alcoholism _____ Leukemia _____
 High Blood Pressure _____ Emphysema & Bronchitis _____
 Other _____

26. What general subject areas of community health education are you interested in? (all, some, none)

A review of pharmacology, pharmacies, and pills for the layman.

Why patients don't follow orders.

Should a patient take his own blood pressure?

Consumerism and health care.

How life style affects you and your family.

Innovations in health testing.

Growth and development: Newborn to Teenager.

Common childhood illnesses: What to look for and do.

How mental illness affects the patient and those around him.

a. Individual resources

b. Community resources

Family planning and special concerns of women.

The great doctor shortage: Is the end in sight?

a. Present and future trends in health care delivery.

b. Use of paramedics and systems in health care.

Consumer Questionnaire - Patient Education (Cont'd)

First-aid, i.e.,

Emergency resuscitation

Mouth-to-mouth

Care of poisoning case

Proper care of burns, sprains, strains, back injuries, etc.

The perils of eating, American style: A basic review of nutrition, vitamins, and practical eating tips.

Other: _____

CONSUMER QUESTIONNAIRE ON PATIENT EDUCATION
(Patient Survey)

N=200
%

DATA	(-) 19	20-29	30-39	40-49	50-59	60-69	70 (+)
Ranges of Ages	22	33	18	18	5	3	1
	Male	Female					
Sex	47	53					
	White	Black	Other				
Race or Ethnicity	59	30	11				
	Active Duty	Retired					
	Officer	EM	Officer	EM	Other		
Military Status of Sponsor	9	64	6	14	7		
	Sponsor	Spouse	Other				
Patient's relationship to Sponsor	46	43	11				
	Ret./ Unemploy.	House- wife	Adminis- trative	Tech. Spec.	Prof- essional	Combat Related	Blue Collar
Occupation	16	31	8	6	0	2	11
							3

%

DATA Married Single Other (divorced, separated, engaged, widowed)

Marital Status	68	25	7
	Elementary School (1-6)	Junior High (7-8)	High School (9-12)
			Bacca-laureate Degree
			1-3 Yrs. College
			Master's Degree
			Doctor's Degree

Education Completed	2	5	62	23	5	3
---------------------	---	---	----	----	---	---

Head of Household	Wife	Other
-------------------	------	-------

Relationship of respondent to Head of Household

50	42	8
----	----	---

Yes	No
-----	----

Do you have any children?

60	40
----	----

Radio	TV	Lecture	Audio Cassette	Bopklet	Combination
-------	----	---------	----------------	---------	-------------

* How would you like this patient and/or community health education presented? Through what media or combination?

5	22	12	9	13	39
---	----	----	---	----	----

* Multiple Response Type Question

	%				
	Medic	Nurse	Physician	Health Educator	Secretary
* Who would you like to present the patient and/or community health education?	16	29	42	34	0
<u>Groups Individually</u>					
Would you prefer to have the information presented in groups or individually?	64	36			
<u>Daytime Evening</u>					
Would you be interested in having the information given during the day or evening?	65	35			
<u>Person Only Family</u>					
Would you prefer to have the information given only to you or would you like the family to participate?	19	81			

* Multiple Response Type Question

%

	Yes	No	**Sometimes
Do you feel the Physicians give you adequate information about your illness in order that you can be an effective self-care agent?	67	22	8

	Yes	No	**Sometimes
Do you feel the nurses give you adequate information about your illness in order that you can be an effective self-care agent?	66	22	7

** Unsolicited Response

%

* If people were informed, which illness(es) would they be concerned about?
(Select all, one, none)

Cancer-----	33%
Heart Disease-----	30%
Diabetes-----	26%
Hypertension-----	26%
Emphysema/Bronchitis-----	16%
Alcoholism-----	15%
Stomach Ulcers-----	11%
Accidents (Vehicle)-----	9%
Other-----	4%
All the Above-----	33%

* Which illness(es) does the average person worry about fairly often?
(Select all, one, none)

Cancer-----	53%
Heart Disease-----	41%
High Blood Pressure-----	38%
Diabetes-----	18%
Pneumonia-----	16%
Leukemia-----	14%
Emphysema/Bronchitis-----	12%
Alcoholism-----	9%
Other-----	1%
All the Above-----	13%

* Multiple Response Type Question

* Which illness(es) does the average person worry about rarely?

%

Alcoholism-----	42%
Emphysema/Bronchitis-----	31%
Pneumonia-----	29%
Leukemia-----	25%
High Blood Pressure-----	17%
Diabetes-----	12%
Heart Disease-----	8%
Cancer-----	6%
Others-----	3%
All the above-----	4%

* What general subject areas of community health education are you interested in?

Common childhood illnesses-----	52%
Growth and development-----	43%
How life style affects you and your family-----	38%
A review of pharmacology, pharmacies, and pills for the layman-----	36%
Consumerism and health care-----	32%
First Aid-----	
Emergency resuscitation-----	32%
Mouth-to-Mouth-----	29%
Care of poisoning-----	31%
Proper care of burns, sprains, etc.-----	31%
The perils of eating, American style-----	31%
How mental illness affects the patient and those around him-----	
Individual resources-----	30%
Community resources-----	30%
Should a patient take his own blood pressure-----	29%
Innovations in health testing-----	27%
Why patients don't follow orders-----	25%
The great doctor shortage: Is the end in sight-----	24%
Family planning and special concerns of women-----	23%
Other-----	4%

* Multiple Response Type Question

APPENDIX E

COMMUNITY SURVEY

COMMUNITY INFORMATION

1. How long have you lived in the Fort Polk area?
2. How do you find living on post/trailer park?
3. Are the services provided there as good, about the same or worse than those provided at other places you have lived?
4. What do you like best about your living area?
5. What do you like least about your living area?
6. Would you prefer to live in another housing area on post? Why?
7. How do you think people from other areas feel about the housing areas?
8. How do you rate this housing area as compared to others?

COMMUNICATION AND TRANSPORTATION

1. Do you have a telephone? _____ Radio _____
number
- T.V. _____ Family car _____
number type who uses it, drives
- Motorcycle _____
who uses it
- Bicycle _____
number - who uses
2. Do you read the local newspapers?
Do you have a home subscription?
Which ones?
Do you prefer any particular one?
3. What about the Post paper, the Kisatchie Guardian, do you read it? _____
Do you like it? _____
4. In what other ways do you get information about what's happening in the world?
examples: friends family members school

Communication and Transportation - Cont'd.

MEDICAL ACTIVITY RELATIONSHIPS:

1. How often do you use the Fort Polk Army Community Hospital for yourself or other family members.
2. Have you or anyone else in the family every been hospitalized there?
3. If yes, how many days were you there?
4. Were you satisfied with the care you or they received there?
 - a. In what ways did the doctors help you?
 - b. In what ways did the nurses help you?
 - c. In what ways did other people on the staff help you?
 - d. In what ways could any of the above hospital staff have helped you?
5. What about outpatient services, how often do you or other family members use these?
6. What does your family like best about the clinic services at the hospital?
7. What does your family like least about clinic services at the hospital?
8. What amount per month do you consider should be added to your pay if you did not have prepaid Army Medical Services? (i.e., What do you think it would cost a family like yours for a civilian prepaid program with equal coverage, such as an H.M.O.?)

How would you rate those of the services that are offered by the hospital,

good

so-so

fair

poor

(circle one)

Are there any other services you think the hospital should offer to this community?

Which of the following problems do you believe require medical attention?
How soon? INSTRUCTIONS TO INTERVIEWER: Do not add any qualifications to
the below "Problems," if you do, the answers wouldn't mean anything and
cannot be compared with each other.

<u>Condition</u>	<u>Reqs. Attn.</u>	<u>How Soon</u>
Loss of appetite		
Sore throat		
Persistent backache		
Continued coughing		
Earache		
Persistent joint and muscle pain		
Blood in stool		
Diarrhea		
Blood in urine		
Excessive vaginal bleeding		
Swelling of ankles		
Loss of weight		
Bleeding gums		
Chronic fatigue		
Shortness of breath		
Persistent headaches		
Fainting spells		
Pain in chest		
Lump in breast		
Lump in abdomen		

NOTE: Use the back of this sheet for comments.

Medical Activity Relationships - Cont'd.

9. Relationship or respondent to head of household: _____
10. What is patient or community health education? Understands ()
Does not understand ()
11. How do you feel about patient and/or community health education?
good () bad () indifferent ()
12. How would you like the patient and/or community health education presented?
Through what medium? _____ Or combination of media? _____
- Radio _____ Tape (audio) Cassette _____
- TV _____ Booklet _____
- Lecture _____ Combination _____
13. Who would you like to present the patient and/or community health education?
- Medic _____ Health educator _____
- Nurse _____ Secretary _____
- Physician _____
- would you prefer to have the information presented in groups or individually?
15. Would you be interested in having the information given during the day or evening?
16. Would you prefer to have the information given only to you or would you like the family to participate?
17. In general, how do you feel about the Army's patient and/or community health education program in the Ft Polk area?
- Excellent _____ Not good _____
- Fairly good _____ Poor _____
18. Do you feel the physicians give you adequate information about your illness in order that you can be an effective self-care agent?

Medical Activity Relationships - Cont'd.

19. Do you feel the nurses give you adequate information about your illness in order that you can be an effective self-care agent?
20. Have you or any member of your family been to see a doctor in the past year?
21. Do you have a particular doctor whom you normally see about your health when something is wrong?
22. How do you find out about changes in hospital procedures?
23. Aside from the medical quality of services at the hospital, are there any practical matters you would like to comment on?

COMMUNITY QUESTIONNAIRE
Patient Education
N = 36

INDIVIDUAL	AGE (-)	19	20-29	30-39	40-49	50-59	60-69	70 (+)
Sponsor		5	31	26	30	5	3	
Spouse		4	20	32	44			
SEX	MALE		FEMALE					
Sponsor	100		100					
Spouse								
RACE	WHITE		BLACK	OTHER				
Sponsor	75		21					
Spouse	84		12					
STU- DENT	RET/ UNEMPL.	HOUSE- WIFE	ADMINIS- TRATIVE	TECH. SPEC.	COMBAT RELATED	BLUE COLLAR	MEDIC	PROFES- SIONAL
Sponsor	15		4	4	82		3	
Spouse	9	77				8	4	

*Multiple Response

(-) 5 6-10 11-15 16-20 20 (+)

CHILDREN'S AGES*

54 54 80 45 10

MARRIED SINGLE OTHER (Separated, divorced, engaged, widowed)

MARITAL STATUS 69 25 6

ELEM. SCHOOL JR. HIGH SCHOOL HIGH SCHOOL BACCA- LAUREATE DEG. MASTER'S DEG. DOC. DEGREE

Sponsor Spouse

54 55 25 25 17 20 4

RELIGION

CHRISTIAN CATHOLIC PROTESTANT JEWISH NO PREF. OTHER

Sponsor Spouse

10 9 14 18 58 69 15 4 3

(-) 6 mo.

6-12 mo.

12-24 mo.

24-36 mo.

36 (+) mo.

How long have you lived in the Fort Polk area?

16

20

20

35

GOOD

WORSE

SAME

Are the services provided there as good, about the same or worse than those provided at other places you have lived?

22

22

56

What do you like best about your living area?

Space	Clean Area	Playgrounds
Close to post	Privacy	
Close to town	Recreation	

What do you like least about your living area?

Humidity	Rain	Number of children
Boredom	Drainage	People
Needs larger city	Poor construction	No recreation

% YES

% NO

Would you prefer to live in another housing area on post?

15

85

How do you think people from other areas feel about the housing area?

LIKE

12%

DISLIKE

6%

DON'T KNOW

82%

How do you rate this housing area as compared to others?

SUPERIOR

16%

SAME

50%

INFERIOR

34%

	TELEPHONE	RADIO	TV	CAR	MOTORCYCLE	BICYCLE
*Do you have one or more of the following?	75%	100%	88%	83%	13%	22%

	LEESVILLE	DERIDDER	KISATCHIE	GUARDIAN	OTHER
--	-----------	----------	-----------	----------	-------

Do you read the local news-papers?

29%	12%	9%	50%
-----	-----	----	-----

	LEESVILLE	DERIDDER	KISATCHIE	GUARDIAN(Post)	OTHER
--	-----------	----------	-----------	----------------	-------

Do you prefer any particular one (paper)?

7%	14%	78%
----	-----	-----

YES	NO	SOMETIMES
-----	----	-----------

Do you read the post newspaper, the Kisatchie Guardian?

81%	16%	3%
-----	-----	----

YES	NO
-----	----

Do you like the Kisatchie Guardian?

54%	46%
-----	-----

*Multiple response

	FRIENDS	FAMILY MEMBERS	SCHOOL	FELLOW WORKERS	OTHER
--	---------	----------------	--------	----------------	-------

*In what other ways do you get information about what's happening in the world?

53%	17%	14%	3%	39%
-----	-----	-----	----	-----

	FREQUENTLY	RARELY	SOMETIMES	NOT AT ALL
--	------------	--------	-----------	------------

How often do you use the Fort Polk Army Community Hospital for yourself or other family members?

21	42	21	16
----	----	----	----

	YES	NO
--	-----	----

84

Have you or anyone else in the family ever been hospitalized there?

52	48
----	----

	0-3	4-7	8-13	14 (+)
--	-----	-----	------	--------

How many days were you there? 69 15 8 8

	YES	NO	DON'T KNOW
--	-----	----	------------

Were you satisfied with the care you or they received?

78	22
----	----

*Multiple response

	FREQUENT	RARELY	NEVER	SOMETIMES
--	----------	--------	-------	-----------

How often do you or other family members use outpatient services?

3	41	35	16
---	----	----	----

What does your family like best about the clinic services at the hospital?

Cost (Free)	Easy appointments	Nothing
Short waiting period	Walk-in appointments	
Family Practice Clinics		

What does your family like least about clinic services at the hospital?

Regulations	Too crowded	Stuffy doctors
Hot hallways	Long waiting time	Poor help
Between buildings		

What amount per month do you consider should be added to your pay if you did not have prepaid Army Medical Services? (i.e., What do you think it would cost a family like yours for a civilian program with equal coverage, such as an H.M.O.?)

Range: \$50 - \$400

Average: \$117.00

GOOD	SO-SO	FAIR	POOR
------	-------	------	------

How would you rate those of the services that are offered by the hospital?

34	34	24	8
----	----	----	---

REQUIRES ATTENTION HOW SOON

Which of the following problems do you believe require medical attention?

Loss of appetite	25	Range 2 days - 2 weeks	Average Avg. - 2 weeks
Sore throat	41	1 day - 1 week	Avg. 2-3 days
Persistent backache	44	1 day - 1 week	Avg. 5 days
Continued coughing	47	1 day - 1 mo.	Avg. 2 weeks
Earache	50	1 day - 1 week	Avg. 2 days
Persistent joint and muscle pain	36	1 day - 3 weeks	Avg. 1 week
Blood in stool	55	Immediately	
Diarrhea	33	1 day - 3 days	Avg. 2 days
Blood in urine	55	Immediately	
Excessive vaginal bleeding	38	2 days - 1 month	Avg. 1 week
Swelling of ankles	36	2 days - 1 month	Avg. 10 days
Loss of weight	27	2 days - 1 month	Avg. 6 days
Bleeding gums	33	1 day - 1 month	Avg. 1 week
Shortness of breath	39	1 day - 2 weeks	Avg. 3-4 days
Persistent headaches	55	1 day - 1 mo.	Avg. 5-6 days
Fainting spells	50	1 day - 2 weeks	Avg. 2-3 days
Pain in chest	47	1 day - 2 weeks	Avg. 2 days
Lump in breast	52	Immediately	
Lump in abdomen	47	Immediately	

Are there any other services you think the hospital should offer to this community?

Patient Assistance Bulletin
Telephone courtesy
Personnel cooperation

Unwed mother counseling
Birth control counseling

More doctors

	HEAD OF HOUSEHOLD	SPOUSE	OTHER (SON, DAUGHTER, PARENTS)
Relationship of respondent to head of household	64	32	4

GOOD BAD INDIFFERENT

How do you feel about patient and/or community health education?

66 34

87

UNDERSTANDS DOES NOT UNDERSTAND

*What is patient or community health education?

62 38

COMB. RADIO TV LECTURE AUDIO CASSETTE BOOKLET

*How would you like this patient and/or community health education presented? Through what media or combination?

19 13 25 13 8 27

MEDIC NURSE PHYSICIAN HEALTH EDU. SECRETARY

Who would you like to present the patient and/or community health education?

17 26 31 34 0

*Multiple response

	<u>GROUPS</u>	<u>INDIVIDUALLY</u>
--	---------------	---------------------

Would you prefer to have the information presented in groups or individually?

62	38
----	----

	<u>DAYTIME HOURS</u>	<u>EVENING HOURS</u>
--	----------------------	----------------------

Would you be interested in having the information given during the day or evening?

42	58
----	----

	<u>PERSON</u>	<u>FAMILY</u>
--	---------------	---------------

Would you prefer to have the information given only to you or would you like the family to participate?

16	84
----	----

	<u>EXCELLENT</u>	<u>FAIRLY GOOD</u>	<u>NOT GOOD</u>	<u>POOR</u>
--	------------------	--------------------	-----------------	-------------

In general, how do you feel about the Army's patient and/or community health education program in the Fort Polk area?

12	56	16	16
----	----	----	----

	<u>YES</u>	<u>NO</u>
--	------------	-----------

Do you feel the physicians give you adequate information about your illness in order that you can be an effective self-care agent?

60	40
----	----

YES NO

Do you feel the nurses give you adequate information about your illness so that you can be an effective self-care agent?

60 40

YES NO

*Have you or any member of your family been to see a doctor in the past year?

78 22

YES NO

Do you have a particular doctor whom you normally see about your health when something is wrong?

69 31

How do you find out about changes in hospital procedures?

From hospital personnel By calling hospital	Post paper From office friends	After t/e fact
--	-----------------------------------	----------------

AD-A195 593

A PATIENT EDUCATION CENTER IN THE US ARMY COMMUNITY
HOSPITAL FORT POLK LOUISIANA(U) ACADEMY OF HEALTH
SCIENCES (ARMY) FORT SAM HOUSTON TX HEALTH C.

2/2

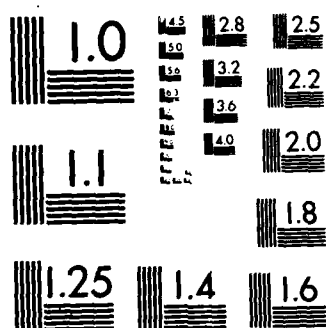
UNCLASSIFIED

J B WILLIAMS AUG 88 HCA-33-88

F/G 6/5

NL





MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

APPENDIX F

MEDICAL RECORD AUDIT

DOCUMENTATION OF PATIENT EDUCATION
Medical Records Audit
21 May 1980

OUTPATIENT CHARTS
(Random Selection)

	<u>NUMBER</u>	<u>TOTAL PERCENT CHARTS</u>	<u>PERCENT DOCUMENTED</u>
Charts Audited	30		
Documented Patient Education	8	26.7	
Patient Understanding	1	3.3	12.5

INPATIENT CHARTS
(Random Selection of Documented
Diabetes Mellitus Cases, CY 1978)

	<u>NUMBER</u>	<u>TOTAL PERCENT CHARTS</u>
Charts Audited	30	
Documented Patient Education	29	96.7
	3.04 times per patient	
Patient Understanding	6	20.0
	1.75 times per patient	

APPENDIX G

AUDIO VISUAL EQUIPMENT LIST

AUDIO VISUAL EQUIPMENT LIST
 Patient Education Center
 US Army Community Hospital, Fort Polk, LA.

<u>ITEM</u>	<u>COST*</u>	<u>NUMBER</u>	<u>TOTAL COST</u>
3/4" video cassette player/rec.	\$995.00	2	\$ 1990.00
TV Monitor	400.00	2	800.00
Singer 8900 - 1 Auto Vance III Film strip projector (Front & rear screen)	249.50	1	249.50
Singer 8888 - 2 Auto Vance II Film strip projector	189.50	4	758.00
Singer Caramite Model 3320 Front & Rear Screen Slide Projector	429.50	1	429.50
16 mm film projector	900.00	1	900.00
35 mm slide projector with accessories	464.55	1	464.55
Projection screen	50.00	2	100.00
		TOTAL	\$ 5691.55

*FY 80 Price List

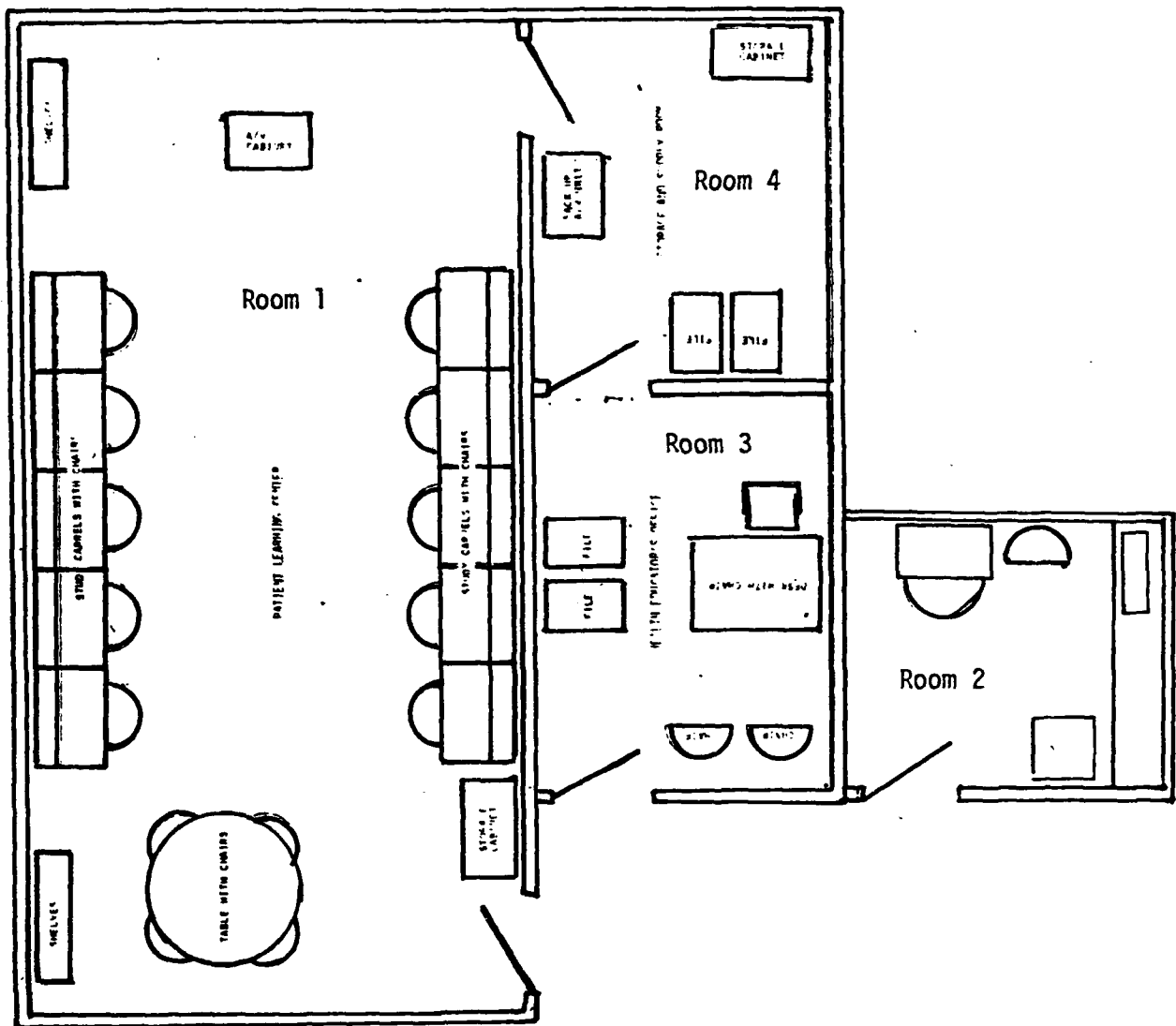
APPENDIX H

PHYSICAL SPACE AND EQUIPMENT (NON-AV) REQUIREMENTS

PHYSICAL SPACE AND EQUIPMENT (NON-AV) REQUIREMENTS

1. Basic Floor Diagram.

Room 1 - Primary Patient Education Center	450 sq ft
Room 2 - Secondary Patient Education Center	100 sq ft
Room 3 - Office, Education Coordinator	120 sq ft
Room 4 - Storage & Supply	100 sq ft
	<hr/> 770 sq ft



2. Physical Facilities.

a. General Requirements.

(1) Size. A small-group facility would be designed to accommodate six to ten patients. The minimum room size would be 300 square feet, preferably 450 square feet (15' x 30'). The size will be dependent on space allocations, type of installation, and patient flow.

(2) Wiring. Minimum requirements of a small sized learning center would be two double outlets on each wall. The outlets should be within easy access to each study carrel and either end of the room. Raceways should be provided for communications units both within the learning center and between other areas of the hospital care facility.

(3) Artificial-Light Control. The light should be adequately diffused and shadow free in all parts of the learning center. Thirty (30) footcandles is recommended as the minimum light level. Light control with dimmer switch should be in the immediate area of the health educator's station.

(4) Acoustical Conditioning. The acoustical conditioning should be controlled by wall coverings (acoustical tile or plaster) and rugs on the floors plus the use of headphones for each patient. Cutting down on the reverberation and noise level improves room "climate" and reduces tensions.

(5) Air Control. Heating, cooling, and ventilating systems should cause neither drafts nor noise. The temperature range as per governmental energy control standards, should be from 68 degrees F. in the winter to 78 degrees F. in the summer and the humidity between 45 and 55 percent with adequate air circulation. It should also be thermostatically controllable and monitored by the health educator.

(6) Color. Colors may vary considerably, depending upon the room's exposure. Pastel colors are suggested to help with lighting and light control.

(7) Reflective Surfaces. For effective use of most projected material, illumination in the room should not exceed 1/10 foot candle.

(8) Rest Room Facilities. Should be provided for both men and women in the immediate area.

b. Furniture and Arrangement.

(1) Primary Learning Center: (Room #1)

(a) Size - 15' x 30': was large enough to accommodate eight patients comfortably. However, may seat ten patients.

(b) Furniture and Facilities.

- chairs,
- 1 one 54" circular table with four posture conforming
 - 2 two sets of five wall mounted shelves,
 - 3 one lectern,
 - 4 two legal size five drawer file cabinets,
 - 5 eight study carrels with posture conforming chairs,
 - 6 one metal cabinet for audio visual equipment,
 - 7 one 18" x 35" x 60" metal, double door storage cabinet.

(2) Secondary Learning Center: (Room #2)

(a) Size - 6' x 12': was large enough to accommodate one patient comfortably. Also used for storage.

(b) Furniture and Facilities.

- 1 one study carrel,
- 2 two posture conforming chairs,
- 3 one metal cabinet for audio visual equipment,
- 4 one 2' x 5 1/2' built in storage cabinet with stainless steel sink, and
- 5 two 25" x 31" wall hung metal cabinets.

(3) Carrels. To afford flexibility a "mix" of types of carrels is recommended, rather than a standardized type. The vertical dividers should not be over two feet above the table area. Study carrels should be used for individualized instruction with a minimum of six and preferably ten patients per small sized learning center.

(4) Cloistering of Carrels. If feasible the carrels should be broken up visually so that they do not have a barnlike, regimented appearance. If space is at a premium there should be no more than five carrels along one wall. Carrels should be arranged to ease the traffic flow, since patients leave at different times.

(5) Social Interaction and Group Size. The interaction and size of the group is dependent upon the topic area (disease entity) and the social characteristics of the patients. The optimum group size is between six to ten patients.

(6) Conference Table. At least one round conference table should be included in the furniture to provide opportunities for various forms of interaction and face-to-face learning activities. When patients are in the carrels the conference table may also serve as the health educator's station.

(7) Seating and Table Surfaces. Seats and table should be movable (designed for flexible grouping), quiet, comfortable, the right height with good posture support. Swivel chairs with casters are suggested.

(8) Learning Materials Storage. The learning center should include shelving both open and visible and hidden (cabinets) shelves to store booklets, 3/4" audiovisual cassettes, other audio visual equipment, etc.

c. Additional Facilities.

(1) Health Educator's Office. Should include a desk, two chairs, and a minimum of two file cabinets. The number of file cabinets would be dependent on the patient case load. This office is essential for baseline collection.

(a) Health Educator's Office.

1 Size: 9' x 11'

2 Furniture and Facilities.

a one study carrel,

b two 18" x 28" legal size five drawer file cabinets,

c one 34" x 44" single pedestal desk,

d three posture conforming chairs,

e four rows of 12" x 48" wall hung shelves,

f one 24" x 37" x 38" built in storage cabinet with stainless steel sink,

g one 13" x 32" x 36" wall hung metal cabinet with sliding glass doors, and

h one TV monitor.

(2) Storage Area and Supply Room. Should be large enough to adequately store blank forms, patient charts, and additional (back-up) audiovisual equipment, including two file cabinets.

(a) Size: 9' x 11'.

(b) Two legal sized 5-drawer file cabinets.

(c) One 18" x 35" x 60" metal, double door storage cabinet.

d. Audio Visual Hardware: See Appendix G.

e. Location: A Patient Education Center should be readily accessible to patients and have an adequate waiting area. In the new hospital, an area within the outpatient area (modular clinic) would be appropriate.

SOURCE: Kucha, Doloros H. "A Comparative Evaluation of the Traditional Versus a Systems Approach for Hypertensive Patient Education," Health Care Studies Division Report (HCSD #79-001-D), Academy of Health Sciences, Fort Sam Houston, Texas, August 1977, p 141-156.

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